Indiana Specific Information

This document contains information specific to the State of Indiana. Please refer to the Provider Reference Guide for general information regarding plan administration.

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1.1 Notice of Updates

Notice of updates published June 9, 2025.

- Updated Indiana Pathways for Aging benefit.

1.2 Covered Benefits – UnitedHealthcare Community Plan – Hoosier Care Connect (Medicaid)

Benefit Plan(s): UDINM-20, UDINM-21

Benefit	Benefit Limitations/Criteria
Exam and Refraction	▪ 1 service date every 12 months. ▪ Additional exams and refractions are covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure
Frame	▪ 1 unit every 12 months ages 20 and under. ▪ 1 service date every 5 years ages 21 and older. ▪ **Frame must be selected from the March frame kit.**

Deluxe Frame	▪ 1 unit every 12 months ages 20 and under or 1 unit every 5 years ages 21 and older in lieu of the standard frame when medically necessary. Medical necessity includes, but is not limited to:
	  ▪ Frames to accommodate facial asymmetry or other anomalies of the:
	  ▪ Head, neck, face or nose.
	  ▪ Allergy to standard frame materials
	  ▪ Specific lens prescription requirements
	  ▪ Frames with special modifications such as ptosis crutch
	  ▪ Provision of frames to an infant where special size frames must be prescribed that are unavailable in the standard selection.
	▪ To identify deluxe frames, please bill with procedure code V2025 and the MSRP or invoice cost of the frame. Documentation must be attached to the claim. Claims submitted without documentation will be denied.
	▪ Frame must be from the provider's selection.

Frame Replacement	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify replacement frames, please bill with modifier U8.**

Lenses	▪ 2 units (1 pair) every 12 months ages 20 and under or 2 units (1 pair) every 5 years ages 21 and older when the following criteria is met for an initial or subsequent pair of glasses.
	  ▪ For one eye, a change of .75 diopters for ages 6 through 20.
	  ▪ For one eye, a change of .75 diopters for ages 21 through 42.
	  ▪ For one eye, a change of .50 diopters for ages 43 and older.
	  ▪ An axis change of at least 15 degrees
	▪ Tint numbers 1 and 2 (including rose A, pink 1, soft lite, cruxite and velvet lite) are covered when medically necessary.
	▪ Safety lenses are covered for corneal lacerations and other severe intractable ocular or ocular adnexal disease.
	▪ Lens, polycarbonate or equal, any index, per lens is covered when a corrective lens is medically necessary and one or more of the following criteria is met.
	  ▪ Member has carcinoma in one eye, and the health eye requires a corrective lens.
	  ▪ Member has only one eye, and that eye requires a corrective lens.
	  ▪ Member had eye surgery and still requires the use of a corrective lens.
	  ▪ Member has retinal detachment or is post-surgery for retinal detachment and requires lens to correct a refractive error of one or both eyes.

Benefit	Benefit Limitations/Criteria
	▪ Member has a cataract in in one eye or is post-cataract surgery and requires a lens to correct a refractive error of one or both eyes. ▪ Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye. ▪ Member has other conditions for which the optometrist or ophthalmologist has deemed polycarbonate lenses to be medically necessary. These conditions must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Lens Replacement	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify replacement lenses, please bill with modifier U8.** ▪ **To identify replacement lenses due to a change in prescription, please bill with modifier SC.**
Necessary Contact Lenses	▪ Covered as needed when medically necessary. Medically necessary documentation must be maintained in the provider's office and shall be subject to post payment review and audit.
Repairs	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify repairs, please bill with modifier U8.**
Non-Covered Services	▪ Surgical eye care.

1.3 Covered Benefits – UnitedHealthcare Community Plan – Indiana Pathways for Aging (Medicaid)

Benefit Plan(s): UDINM-PAG

Benefit	Benefit Limitations/Criteria
Exam and Refraction	▪ 1 service date every 12 months. ▪ Additional exams and refractions are covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure
Frame	▪ 1 service date every 12 months. ▪ Frame may be selected from the March frame kit OR a $170 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. **To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames**.

Deluxe Frame	▪ 1 unit every 12 months in lieu of the standard frame when medically necessary. Medical necessity includes, but is not limited to:
	  ▪ Frames to accommodate facial asymmetry or other anomalies of the:
	  ▪ Head, neck, face or nose.
	  ▪ Allergy to standard frame materials
	  ▪ Specific lens prescription requirements
	  ▪ Frames with special modifications such as ptosis crutch
	  ▪ Provision of frames to an infant where special size frames must be prescribed that are unavailable in the standard selection.
	▪ To identify deluxe frames, please bill with procedure code V2025 and the MSRP or invoice cost of the frame. Documentation must be attached to the claim. Claims submitted without documentation will be denied.
	▪ $170 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. **To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames**.

Frame Replacement	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify replacement frames, please bill with modifier U8.**
Lenses	▪ 2 units (1 pair) every 12 months when the following criteria is met for an initial or subsequent pair of glasses. ▪ For one eye, a change of .50 diopters ▪ An axis change of at least 15 degrees ▪ Tint numbers 1 and 2 (including rose A, pink 1, soft lite, cruxite and velvet lite) are covered when medically necessary. ▪ Safety lenses are covered for corneal lacerations and other severe intractable ocular or ocular adnexal disease. ▪ Lens, polycarbonate or equal, any index, per lens is covered when a corrective lens is medically necessary and one or more of the following criteria is met. ▪ Member has carcinoma in one eye, and the health eye requires a corrective lens. ▪ Member has only one eye, and that eye requires a corrective lens. ▪ Member had eye surgery and still requires the use of a corrective lens. ▪ Member has retinal detachment or is post-surgery for retinal detachment and requires lens to correct a refractive error of one or both eyes. ▪ Member has a cataract in in one eye or is post-cataract surgery and requires a lens to correct a refractive error of one or both eyes.

Benefit	Benefit Limitations/Criteria
	▪ Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye. ▪ Member has other conditions for which the optometrist or ophthalmologist has deemed polycarbonate lenses to be medically necessary. These conditions must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye. ▪ **Lenses are provided by the March lab <u>OR</u> a $170 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the $170 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for March lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses.** ▪
Lens Replacement	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify replacement lenses, please bill with modifier U8.** ▪ **To identify replacement lenses due to a change in prescription, please bill with modifier SC.**
Contact Lenses	▪ **$170 retail allowance may be used toward a 12-month supply of contact lenses in lieu of frame and lenses when medically necessary. Allowance may be applied towards the fitting.**
Repairs	▪ Covered as needed due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. Documentation must be maintained in the provider's office and shall be subject to post payment review and audit. ▪ **To identify repairs, please bill with modifier U8.**
Non-Covered Services	▪ Surgical eye care.

1.4 Covered Benefits – UnitedHealthcare Dual Complete® IN-S002 (Medicare) H2001-027

Benefit Plan(s): UDINS-DC5

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.5 Covered Benefits – UnitedHealthcare Dual Complete® IN-D001 (Medicare) H2001-057

Benefit Plan(s): UDINS-DC6

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $200 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.6 Covered Benefits – UnitedHealthcare Dual Complete® IN-S001 (Medicare) H2001-064

Benefit Plan(s): UDINS-DC7

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.7 Covered Benefits – UnitedHealthcare Dual Complete® IN-S3 (Medicare) H2001-067

Benefit Plan(s): UDINS-DC4

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.8 Reimbursement Procedures for Deluxe Frame

The UnitedHealthcare Community Plan Hoosier Care Connect and Indiana Pathways for Aging benefits include the option for a deluxe frame if medically necessary. To identify a deluxe frame due to medical necessity, providers must bill with procedure code V2025 and the MSRP or invoice cost of the frame. Documentation must be submitted with the claim. Please clearly identify if documentation reflects MSRP or invoice. Billed charges should reflect the MSRP or invoice cost of the frame. Reimbursement will be up to 75% of the MSRP or up to 120% of the cost of invoice.

1.9 Reimbursement Procedures for Indiana Pathways for Aging (Medicaid)

The Indiana Pathways for Aging benefit affords members the opportunity to:

- Select eyeglasses from the March frame kit and lab, OR
- Select eyeglasses from the provider's selection and in-house lab using a $170 retail allowance, OR
- Select contact lenses from the provider's selection in lieu of eyeglasses using a $170 retail allowance.

The following examples illustrate reimbursement when the allowance is used. These examples are for illustrative purposes only and may not reflect actual amounts unless stated otherwise.

Frame and Lenses

Providers must bill the current and appropriate HCPCS codes for materials along with the usual and customary charges for those codes. Reimbursement will be the lesser of billed charges or billed charges up to 100% of the allowance amount.

When the allowance is used for frames and lenses, it will be applied in the following order:

1. Basic lens codes (V2100-V2399)
2. Frame codes (V2020, V2025)
3. Any remaining allowance will be applied to lens upgrades such as tinting, scratch coating, polycarbonate lenses, etc.
4. Dispensing/fitting fees are not reimbursable

The following example assumes a $170 allowance and billed charges exceeding the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 100.00	$ 80.00
V2100	Lens	$ 80.00	$ 80.00
V2745	Tint	$ 35.00	$ 10.00
92340	Fitting*	$ 25.00	$ 0.00
Total		**$ 240.00****	**$ 170.00**

* Fitting is not reimbursable. This fee is not billable to the member.
**Member is responsible for charges exceeding their $170 benefit allowance. In this example, the member is responsible for $70.

The following example assumes a $170 allowance and billed charges less than the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 35.00	$ 35.00
V2100	Lens	$ 25.00	$ 25.00
Total		**$ 60.00***	**$ 60.00**

*Member is responsible for charges exceeding their $170 benefit allowance. In this example, there is no member responsibility.

Retail Allowance – Contact Lenses

Providers must bill the current and appropriate HCPCS code(s) for contact lenses, and CPT code for contact lens fitting.

Example 1

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 75.00	$ 75.00
92310	Contact Lens Fitting	75	$ 25.00	$ 25.00
Total			**$ 100.00***	**$ 100.00**

*Member is responsible for charges exceeding their $170 benefit allowance. In this example, there is no member responsibility.

Example 2

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 175.00	$ 170.00
92310	Contact Lens Fitting	75	$ 25.00	$ 0.00
Total			**$ 200.00***	**$ 170.00**

*Member is responsible for charges exceeding their $170 benefit allowance. In this example, the member is responsible for $30.